IF APPLICABLE, PLEASE RETURN WITH YOUR PAYMENT

2012 Medication Form

984 Tuckerton Road, Marlton, New Jersey 08053 856-985-9792, Ext. 3 Fax 856-985-2878

MEDICATION

I request the enclosed medication, **in its original container**, be administered to my child and shall release all Township of Evesham personnel from any and all liability related to the submitted medication.

Child's Name _____

Name of Medication _____

Dosage _____

Purpose _____

Parent/Guardian (Please Print) Parent/Guardian Signature Date

PHYSICIAN'S ORDERS

Patient's Name _____

Name of Medication _____

Date of Prescription _____

Dosage _____

Purpose _____

Comments _____

I have instructed and approve the above patient to self-administer their rescue inhaler or EpiPen.

Doctor's Name (Please Print) Doctor's Signature Date